SSI Assisted Living Arrangement- Category D Verification

To: Social Security Administration
From: Department of Human Services - Medical Assistance Designated Agent

This form serves as an intent for the named individual to file for all potential benefits under the Supplemental Security Income, Title XVI program.

To be completed by the referrer.

I. RESIDENT'S NAME: _____D.O.B _____

SSN: _____

TELEPHONE NUMBER: _____

PLANNED FACILITY AND
MOVE IN DATE_____

CURRENTLY RECEIVING SSI? YES ____NO ____

RESIDENT CONTACT: _____
(PERSON WHO IS HELPING RESIDENT WITH SSI APPLICATION)

PHONE NUMBERS: _____
(INCLUDE DAYS AND TIMES TO BE REACHED)

ADDRESS: _____

To be completed by the Assisted Living Residence.

II. RESIDENCE NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

RESIDENCE CONTACT:_____

****CONFIRMED MOVE IN DATE _____**

****CHECK IF CHANGE OF RESIDENCE _____**

*****FOR OFFICE USE ONLY *****

THIS NOTICE IS TO VERIFY THAT THIS RESIDENT HAS BEEN ASSESSED AND REQUIRES ASSISTANCE WITH A MINIMUM OF ONE DAILY TASK SUCH AS MEDICATION MANAGEMENT AND PERSONAL CARE

EFFECTIVE: _____ _____ _____
MONTH DAY YEAR

_____ _____
SIGNATURE OF MA DESIGNATED AGENT DATE Title

Please return this form to:
Department of Human Services, Center for Adult Health
600 New London Ave.
Cranston, RI 02920
Fax: 462-6339
Retain a copy for your records

7/17/2008